Background

The mission of the Chronic Disease Risk Reduction community grant program is to address chronic disease risk reduction through evidence-based strategies that impact tobacco use, physical activity, and nutrition. Chronic diseases account for roughly 75 percent of health care costs each year.[1] Based on national estimates in 2010, nearly $20 billion was spent in Kansas on chronic disease.[2] As states struggle to meet the staggering costs of health care, the most cost-effective interventions are frequently overlooked. Impressive achievements in population health are possible by reducing the prevalence of risk factors that underlie chronic disease and injury and by helping people actively manage their chronic conditions.

SOCIAL DETERMINANTS OF HEALTH - Social determinants of health are conditions in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes. Social determinants of health are, in part, responsible for the unequal and avoidable differences in health status with and between communities.[3] Many chronic conditions are more common, diagnosed later, and result in worse outcomes for particular individuals. Well-known factors include low socioeconomic status, low educational status, and inadequate access to (or utilization of) quality health care. There are other adverse determinants of health as well. Examples include residence in geographic areas that have poor environmental conditions (e.g., violence, poor air quality, and inadequate access to healthy foods), racism, inadequate personal support systems, limited literacy, and limited English proficiency (LEP). These determinants are often associated with racial and ethnic minority and underserved communities, and are among the determinants of health.[4]

While health disparities can be addressed at multiple levels, the Chronic Disease Risk Reduction program focuses on policy, systems, and environmental strategies designed to address health equity and improve the social determinants of health. Health equity is the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally, with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.[4]

Throughout the work plan strategies, Chronic Disease Risk Reduction applicants are required to describe how proposed work plan interventions will address health equity in their community to improve the health of all Kansans.

HEALTH DISPARITIES AROUND TOBACCO USE AND OBESITY

TOBACCO USE - Tobacco use is the leading cause of preventable death and disease in Kansas. Annually, cigarette use alone causes approximately 4,400 deaths in Kansas, costing more than $1.12 billion in medical

[1] The Power to Prevent, Call to Control: At A Glance 2009. Centers for Disease Control and Prevention website. Available at: www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm. Accessed December 14, 2012.

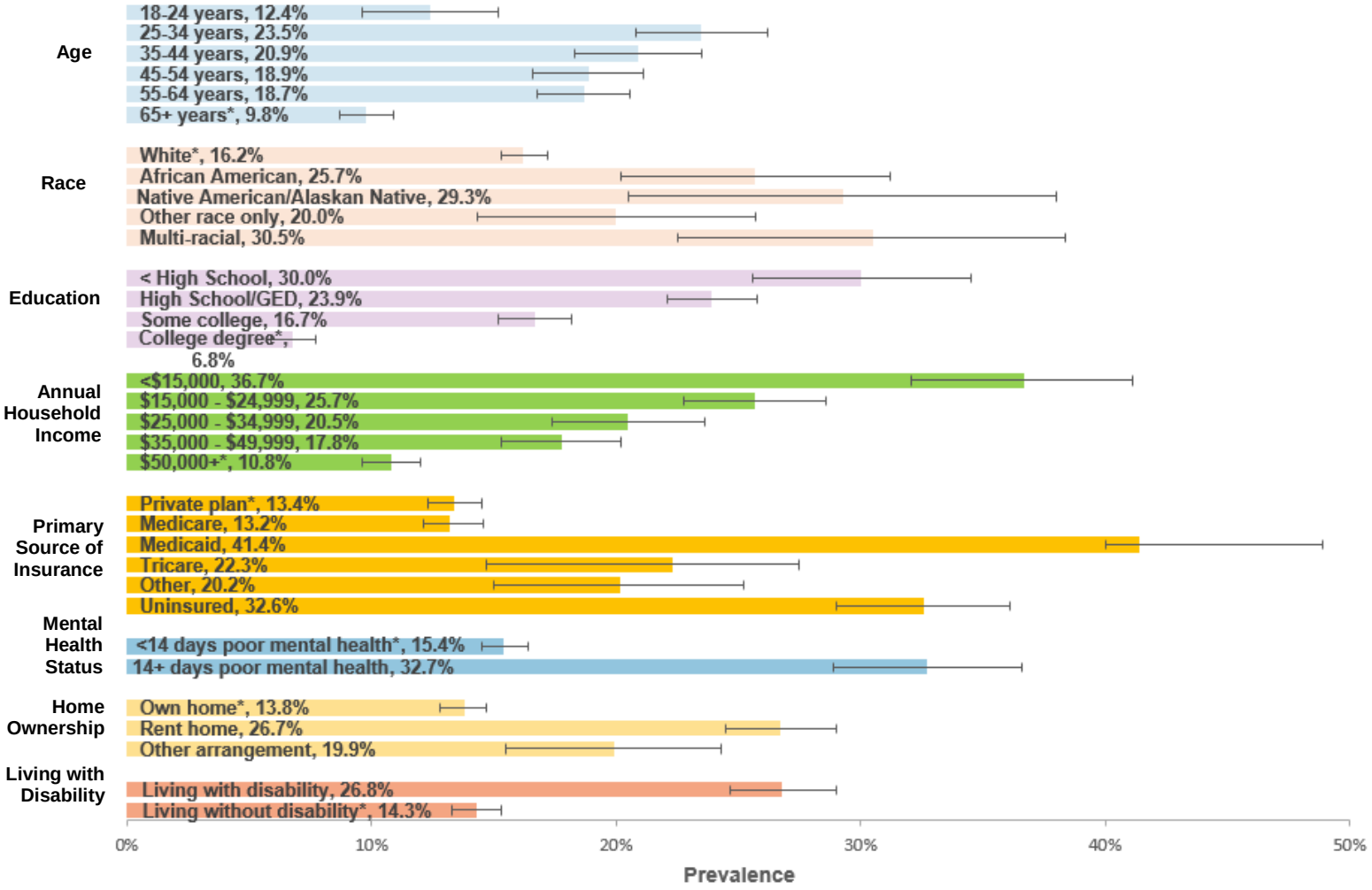
[2] U.S. Health Care Costs. Kaiser Family Foundation, Kaiser EDU website. Available at http://www.kaiseredu.org/issue-modules/us-health-care-costs/background-brief.aspx#footnote/. Accessed December 17, 2012.

[3] Healthy People 2020. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health. Accessed November 1, 2016,

[4] National Partnership for Action to End Health Disparities. **National Stakeholder Strategy for Achieving Health Equity**. Rockville, MD: U.S. Department of Health & Human Services, Office of Minority Health, [April 2011] https://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_05_Section1.pdf

expenditures and $1.09 billion in lost productivity.[5] The prevalence of smoking among adults age 18 and older has declined significantly in Kansas from 22.0 percent (95% CI: 21.2% - 22.8%) in 2011 to 17.2 percent (95% CI: 16.3% - 18.1%) in 2016.[6] Despite overall declines in cigarette smoking, some population groups have disproportionately higher rates of smoking. For example, nearly four in ten adults with an annual household income of less than $15,000 smoke compared to about one in ten adults with an annual household income of $50,000 or more.[6] Additionally, adults who rent their home have a significantly higher prevalence than adults who own their home. [6] However, prevalence of current smoking does not significantly differ by type of residence (adults residing in multi-unit housing: 19.4%, 95% CI: 15.9% - 23.0%; adults residing in single family homes: 16.2%, 95% CI: 14.8% - 17.6%).[6] Figure 1 displays the prevalence of current smoking by common disparities such as age, race, education, annual household income, insurance status, living with a disability, home ownership, and mental health status.

Figure 1: Prevalence of current smoking among Kansas adults aged 18 years and older varies by age, race, education, annual household income, primary source of insurance, living with a disability, home ownership, and mental health status (2016 KS BRFSS[5])



Although smoking prevalence does not differ by population density in Kansas, there is substantial geographic variation. County prevalence rates of current smoking among adults vary from a low of 11.2 percent (95% CI: 9.9% - 12.6%) to a high of 31.9 percent (95% CI: 21.1% - 42.7%) and regional estimates vary from 13.5 percent

[5] Campaign for Tobacco-Free Kids. http://www.tobaccofreekids.org/facts_issues/toll_us/kansas. Accessed November 1, 2016.

[6] 2016 Kansas Behavioral Risk Factor Surveillance System. Kansas Department of Health and Environment, Bureau of Health Promotion.

(95% CI: 9.4% - 17.6%) to 25.1 percent (95% CI: 19.3% - 31.0%).[7] The 2016 KS BRFSS also found that 11.2 percent (95% CI: 10.1% - 12.4%) of adult males in Kansas use smokeless tobacco and 4.9 percent (95% CI: 4.4% - 5.5%) of adults currently use electronic cigarettes (e-cigarettes).[6]

Despite the substantial disparities, 55.4 percent (95% CI: 52.5% - 58.3%) of current smokers in Kansas tried to quit smoking in the past year and members of sub-populations disproportionately impacted by tobacco use are equally interested in quitting.[6]

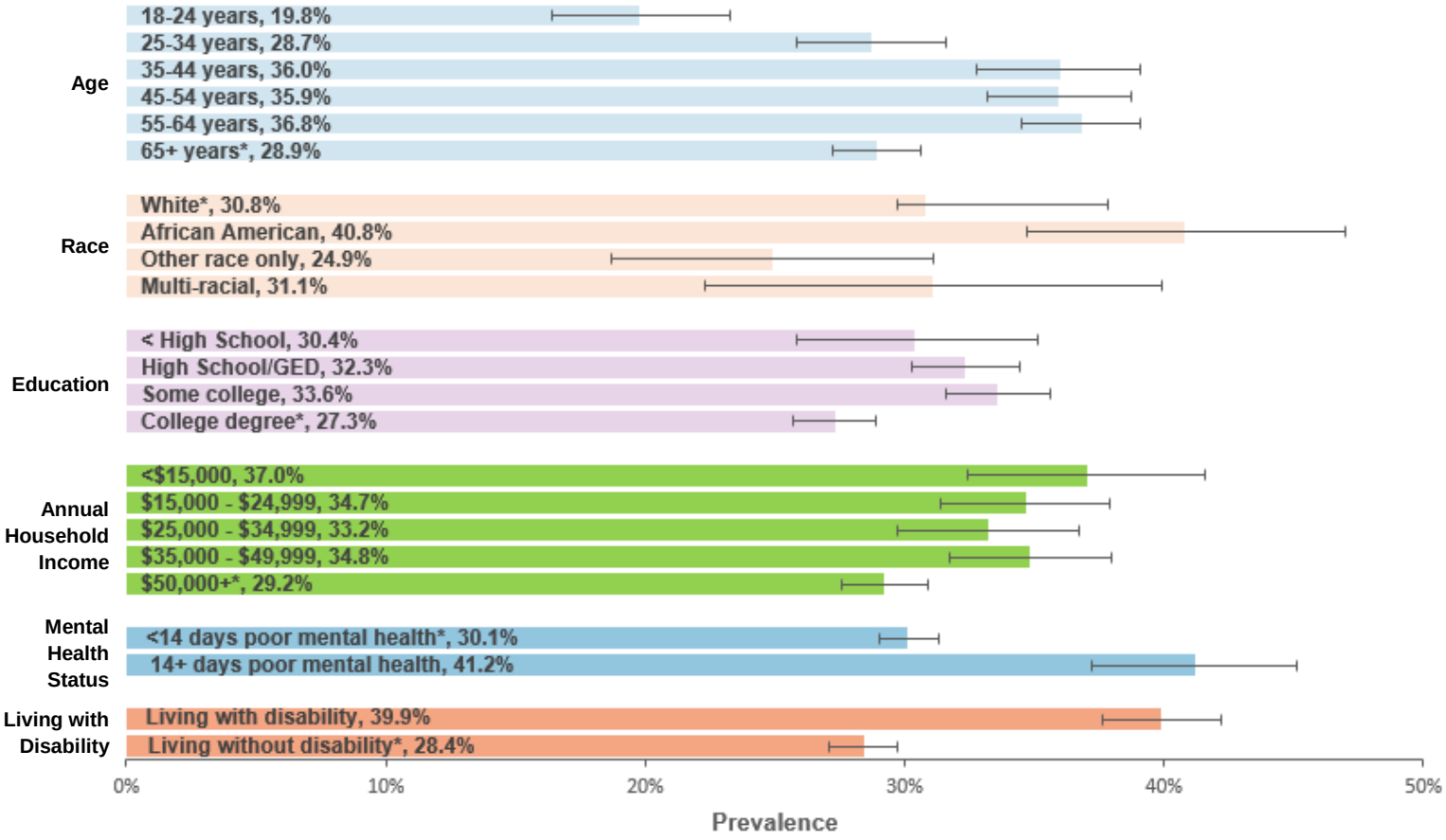
Additionally, youth tobacco use remains an important issue that needs to be addressed. Data from the 2017 Kansas Youth Risk Behavior Survey (KS YRBS) reveal that 7.2 percent (95% CI: 5.6% - 9.1%) of high school students reported currently using cigarettes.[8] The 2017 KS YRBS also indicates that 9.1 percent (95% CI: 7.3% - 11.1%) of male high school students in Kansas currently use smokeless tobacco and 10.6 percent (95% CI: 8.7% - 12.9%) of high school students use e-cigarettes.[8]

The Centers for Disease Control and Prevention has resources that provide information and examples that may be useful in reducing health disparities and advancing health equity in tobacco control. *Health Equity in Tobacco Prevention and Control* and *A Practitioner's Guide for Advancing Health Equity*, and *Community Strategies for Preventing Chronic Disease Tobacco Free Living Strategies*.

OBESITY - Obesity, defined as a body mass index (BMI) greater than 30 kg/m^2, increases the risk for several chronic diseases including coronary heart disease, type 2 diabetes, certain cancers, stroke and osteoarthritis.[9] The prevalence of obesity decreased significantly in 2016. Currently, nearly one in three Kansas adults aged 18 years and older is obese (31.2 percent, 95% CI: 30.1% - 32.3%).[6] As with tobacco use, there are specific sub-populations in Kansas who are disproportionately impacted by obesity. Figure 2 shows disparities in the percentage of Kansas adults who are obese. The percentage of Kansas adults who are obese is significantly higher among Kansans in all age groups compared to those aged 18 – 24 years, persons with lower annual household incomes compared to those earning $50,000 or more annually, and those living with a disability or with poor mental health status. Obesity prevalence is also higher among African Americans.[6] In 2017, 28.4 percent of Kansas high school students were overweight or obese (15.3% overweight, 95% CI: 13.4% - 17.3%; 13.1% obese, 95% CI: 11.3% - 15.0%).[8]

[7] 2015 Kansas Behavioral Risk Factor Surveillance System. Kansas Department of Health and Environment, Bureau of Health Promotion.
[8] 2017 Kansas Youth Risk Behavior Survey. Kansas State Department of Education.
[9] U.S. Department of Health and Human Services. Public Health Service; National Institutes of Health; National Heart, Lung and Blood Institute. Clinical guidelines on the identification, evaluation and treatment of overweight and obesity in adults. NIH Publication No. 98-4083; 1998.

Figure 2: Prevalence of obesity among Kansas adults aged 18 years and older varies by age, race, education, annual household income, living with a disability, and mental health status (2016 KS BRFSS[5])

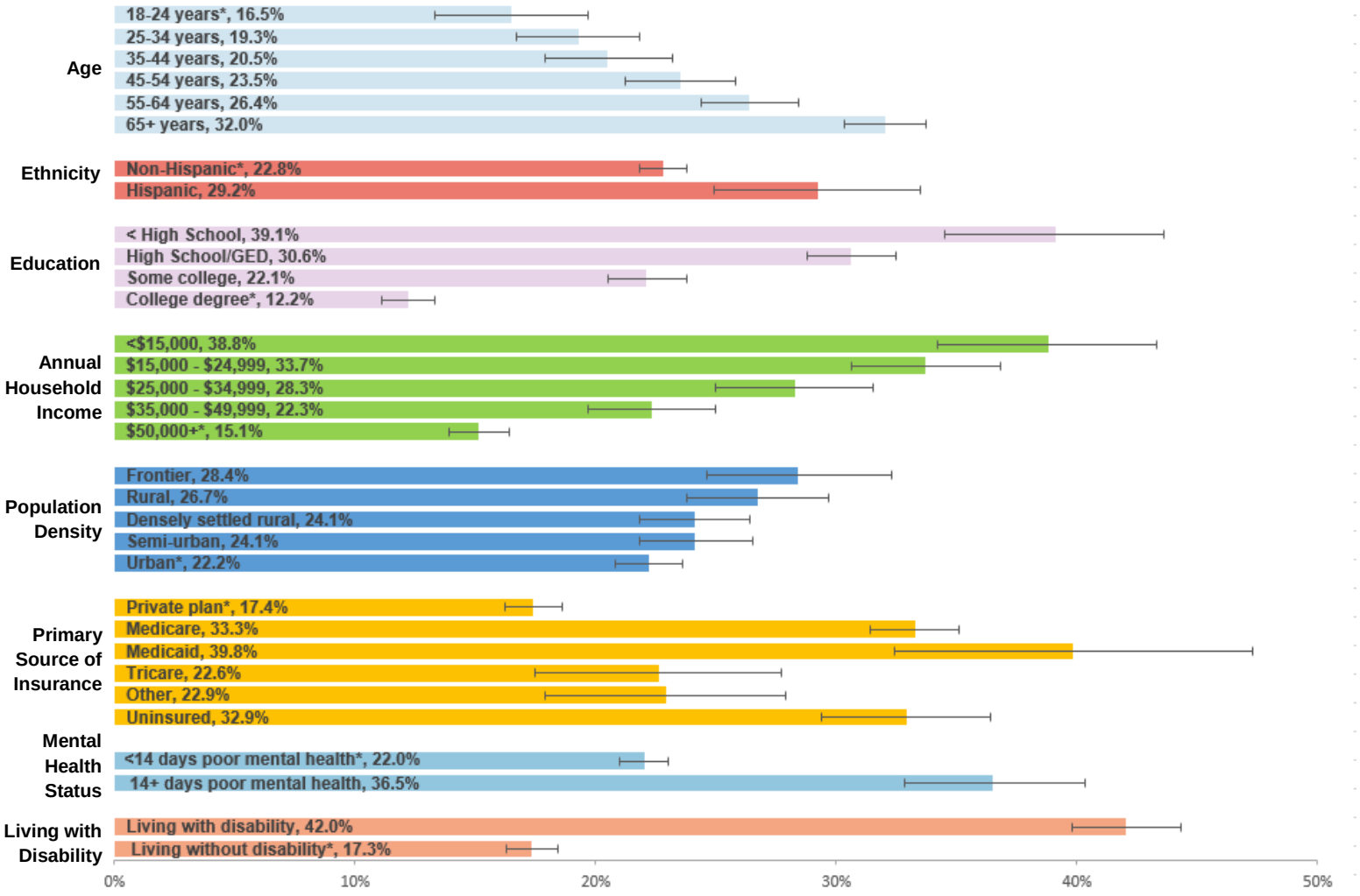


LEISURE TIME PHYSICAL ACTIVITY - Regular physical activity is associated with reduced risk of several chronic health conditions including coronary heart disease, stroke, type 2 diabetes and certain cancers.[10] Participating in physical activity also delays the onset of functional limitations,[11] prevents obesity[9] and is essential for normal joint health.[12] The U.S. Department of Health and Human Services' *2008 Physical Activity Guidelines for Americans* recommend that adults avoid physical inactivity. The *Guidelines* also recommend that children and adolescents participate in at least 60 minutes of physical activity per day.

In 2016, 23.5 percent (95% CI: 22.5% - 24.5%) of Kansas adults did not participate in any physical activity other than their regular job during the past month.[5] Figure 3 shows disparities in the percentage of Kansas adults that did not participate in any physical activity other than their regular job. Disparities exist by age, ethnicity, education, income, population density, living with a disability and mental health. The majority of these disparities occur in the same populations that are disproportionately impacted by obesity. Kansas adults who have lower education, lower annual household incomes, are living with a disability or have poor mental health status have higher prevalence of obesity and a greater percentage who do not participate in any physical activity other than their regular job. In 2017, only 26.5 percent (95% CI: 23.3% - 30.0%) of Kansas high school students engaged in recommended levels of physical activity (i.e., at least 60 minutes per day).[13]

[10] U.S. Department of Health and Human Services. *2008 Physical Activity Guidelines for Americans.*
[11] Huang Y, Macera CA, Blair SN, Brill PA, Kohl HW, Kronfeld JJ. Physical fitness, physical activity, and functional limitations in adults 40 and older. *Medicine Science in Sports and Exercise.* 1998;30:1430-1435.
[12] Minor MA. Exercise in the treatment of osteoarthritis. *Rheum Dis Clin North Am.* 1999;25:397-415.
[13] 2017 Kansas Youth Risk Behavior Survey, Kansas State Department of Education.

Figure 3: Prevalence of no leisure time physical activity among Kansas adults aged 18 years and older varies by age, ethnicity, education, annual household income, population density, insurance status, primary source of insurance, living with disability, and mental health status (2016 KS BRFSS[5])



NUTRITION - Research shows that eating at least two and a half cups of fruits and vegetables per day is associated with a reduced risk of many chronic diseases, including cardiovascular disease and hypertension. A diet rich in fruits and vegetables can also help adults and children achieve and maintain a healthy weight.[14] In 2015, one in five Kansas adults 18 years and older (22.3 percent, 95% CI: 21.6% - 23.1%) consumed vegetables less than 1 time per day.[15] The percentage of Kansas adults who consumed vegetables less than 1 time per day was significantly higher among males, adults age 18-24 years, African Americans, and those with lower education, lower annual household income, living with a disability or poor mental health.[15] In 2015, 43.7 percent (95% CI: 42.9% - 44.6%) of Kansas adults consumed fruit less than 1 time per day. Some of sub-populations with significantly lower fruit consumption are similar to those noted for vegetable consumption. The percentage of adults who did not consume fruit at least once per day is significantly higher among males, adults age 18 to 24 years, and among those with lower education, annual household incomes of less than $15,000, living with a disability and poor mental health status. In 2017, only 12.5 percent (95% CI: 11.0% -

[14] U.S. Department of Agriculture and U.S. Department of Health and Human Services. *Dietary Guidelines for Americans, 2010*. 7th Edition, Washington, DC: U.S. Government Printing Office;2010.

[15] 2015 Kansas Behavioral Risk Factor Surveillance System. Kansas Department of Health and Environment, Bureau of Health Promotion.

14.2%) of Kansas high school students ate fruit or drank 100% fruit juice three or more times per day and only 9.1 percent (95% CI: 7.9% - 10.4%) ate vegetables three or more times per day.[13]

CHRONIC DISEASE SELF-MANAGEMENT EDUCATION - Chronic Disease Self-Management Education (CDSME) programs are evidence-based classes with curriculum developed by Stanford University and licensed by the Self-Management Resource Center to improve the quality of life of those living with chronic disease.[16] The program specifically addresses arthritis, diabetes and lung and heart disease, but teaches skills useful for managing a variety of chronic diseases. KDHE is one of two license-holders in Kansas to implement these programs. Workshops are held once a week for six weeks and led by two trained leaders, one of whom is living with a chronic condition. Workshop participation is recommended for anyone living with one or more chronic conditions, family and friends of those living with a chronic condition and caregivers. These interactive workshops provide participants with techniques to deal with problems associated with chronic disease, nutrition, appropriate exercise, appropriate use of medications, communicating effectively with family, friends and health professionals and how to evaluate new treatments. Participants also learn and practice problem-solving and action planning.

Chronic Disease Risk Reduction (CDRR) Grant Request for Proposal

The purpose of this grant program is to provide funding and technical assistance to communities to address chronic disease risk reduction through evidence-based strategies and best practices that impact tobacco use, physical activity, nutrition and chronic disease self-management.

All applications must address tobacco, while work in physical activity, nutrition and CDSME is optional. This document provides background and guidelines for developing a full proposal and submission instructions. This is a competitive grant process, meaning that grants will be awarded based upon the quality and clarity of the proposed activities and achievability of proposed outcomes. Please follow the directions carefully.

The grant program is structured to promote community program progress in two distinct phases:

1. ***Planning and Capacity (1 year maximum):*** This phase is appropriate for applicants who lack a functioning chronic disease control coalition. Planning applicants should **not** select interventions.

   Planning and Capacity Phase Deliverables:

   - Functional chronic disease prevention coalition. All CDRR grantees are required to have a community coalition or a subcommittee of a larger community health coalition that focuses on tobacco strategies.
   - Attend the annual Community Health Promotion Summit, two other CDRR approved trainings and three CDRR regional grantee meetings.
   - Community chronic disease prevention plan based on community data available from existing sources.

   Timeline and Staffing:

   - Maximum of one year
   - 0.25 FTE minimum (a minimum of 10 hours per week)
   - 25 percent local match

[16]https://www.selfmanagementresource.com/programs/

2. ***Implementation:*** This is appropriate for applicants with a functioning coalition. Grant funds support local tobacco control, physical activity, nutrition and chronic disease self-management programming.

   Implementation Phase Deliverables:

   - Tobacco use and prevention activities
   - Functional chronic disease prevention coalition that meets at least quarterly. All CDRR grantees are required to have a community coalition or a subcommittee of a larger community health coalition that focuses on tobacco strategies outlined in the work plans.
   - Attend the annual Community Health Promotion Summit, two other CDRR approved trainings and three CDRR regional grantee meetings.

   Timeline and Staffing:

   - 0.25 FTE minimum (a minimum of 10 hours per week)
   - 25 percent local match

GRANTEE REQUIREMENTS (if awarded):

Administration and Management

Requirement	Implementation	Planning
1. Participate in CDRR technical assistance and professional development opportunities.	yes	yes
2. Host one mid-year Community Health Specialist site visit by December 30 and participate in bi-monthly progress calls.	yes	yes
3. Report progress at the workplan level at least 5 days prior to bi-monthly calls and site visits and at mid-year (due Jan. 15) and year-end (due July 15). Where applicable, progress should include a description of how underserved populations are engaged and reached.	yes	yes
4. Submit all communications items to Community Health Specialist for review at least two weeks prior to date needed.	yes	yes
5. Consult KDHE epidemiologist to identify appropriate methods for addressing any perceived data gaps. This consult should be initiated during the initial brainstorming phase.	yes	yes
6. Report performance measures at mid-term and final.	yes	no

Data and Information Activities

Requirement	**Implementation**	**Planning**
1. Leverage data available from existing sources to determine community's needs and justify selected workplans.	yes	yes
2. Recruit schools and administer youth surveillance as requested (e.g., Youth Tobacco Survey, Youth Risk Behavior Survey).	yes	yes
3. Collect and submit local policies as passed.	yes	yes
4. For communities awarded CDSME funding, document workshops, potential program delivery partners and referring providers or organizations as instructed.	yes	no

Interventions to Improve Public Health Activities

Requirement	**Implementation**	**Planning**
1. Must select at least one workplan under the goal area Preventing Youth Initiation of Tobacco Use Among Young People or Eliminating Nonsmoker's Exposure to Secondhand Smoke.	yes	no
2. Must engage youth in activities in the goal area Preventing Youth Initiation of Tobacco Use Among Young People.	yes	no, but we recommend connecting with schools and youth leaders, and promoting Resist.

Communications and Promotion Activities

Requirement	Implementation	Planning
1. Integrate Kansas Tobacco Quitline and Brief Tobacco Intervention promotion into tobacco control activities.	yes	no
2. If you perform paid media activities (advertisements in newspapers, billboards or paid content on social media), input the information into the required reporting system.	yes	no
3. Capitalize on local interventions, national reports/data releases and current events to generate at least four instances of earned media. Record into the required reporting system.	yes	yes, may not have four instances
4. Perform at least two public relations efforts geared toward policy makers and focused on priority policy issues. Record into the required reporting system.	yes	no
5. Complete one success story per approved program area per year: one for tobacco, one for PAN and one for CDSME, if applicable. Use the Success Story form.	yes	no

Partnership Activities

Requirement	Implementation	Planning
1. Create and/or maintain a diverse chronic disease prevention/health promotion coalition, with representation from targeted priority populations, that meets at least quarterly.	yes	yes
2. Create and/or maintain a community coalition or a subcommittee of a larger community health coalition that focuses on **tobacco strategies** and that meets at least quarterly.	yes	yes
3. Periodically complete CDRR Coalition Assessment to improve coalition planning and function.	yes	no

Eligibility

Eligible applicants are local health departments, which are expected to serve as the project lead on behalf of the community. A local health department may designate a partner organization to serve as the lead agency. If a partner organization is to serve as the lead agency, the application must include a letter from the local health department stating that it has designated another agency to be the applicant. A consortium of counties may apply together under one application.

Match

All applicants must provide a minimum of 25 percent match for every dollar awarded. The 25 percent match may be in cash, in-kind or a combination of both from county and/or public and private sources. Sources of in-kind match may include grants that compliment tobacco prevention, physical activity and nutrition. Local

funds that support existing evidence-based cessation program services and local funds provided for enforcement activities may also serve as local match. Please consult your Community Health Specialist for assistance in determining the source or amount of cash match required for a specific program. The applicant must document all costs used to satisfy the matching requirements. Program resources may be used for consultants, staff, survey design and implementation, data analysis, or other expenses associated with surveillance and evaluation efforts to fulfill the match requirement.

Available Funding and Budget

Tobacco prevention funding is contingent upon appropriations by the Kansas State legislature. Physical activity, nutrition and CDSME activity funding is contingent upon availability of funds. Awards are competitive and requests typically exceed available funds.

The budget should be entered using the Kansas Grant Management System (KGMS) with detailed budget item descriptions. Describe each staff member's role and responsibilities. The CDRR form "Salary Worksheet" should be completed and uploaded into KGMS. The "Salary Worksheet" is available for download with KGMS.

Funds may be used for reasonable costs associated with the program's activities including:

- ✓ salary
- ✓ travel
- ✓ registration fees
- ✓ supplies
- ✓ advertising, signage (requires prior approval from the Communication Coordinator to ensure statewide coordination)
- ✓ consultation
- ✓ facility rental
- ✓ equipment rental
- ✓ speakers/presenters
- ✓ educational materials

Grant Funds may **NOT** be used to:

- ✗ provide meals or snacks
- ✗ provide direct services, individual or group cessation services
- ✗ provide direct patient care or rehabilitation
- ✗ provide personal health services medications (NRT therapy)
- ✗ supplant existing funding from Federal, State, or private sources
- ✗ directly enforce policies
- ✗ pay for an internship
- ✗ provide incentives and promotional items
- ✗ provide staff time for direct classroom instruction of students of any age
- ✗ lobby government entities, or defray other costs associated with the treatment of diseases
- ✗ purchase capital equipment

Communities are encouraged to get partner contributions for food, which may be used as matching funds.

Review Procedures

Applications will initially be reviewed for completeness and responsiveness. Incomplete applications and applications that do not meet the eligibility criteria will not advance for further review. Applicants will be notified if their applications did not meet eligibility or published submission requirements.

Community Health Promotion staff may respond to questions regarding application processes. However, to provide an equitable and fair process to all applicants, staff will not respond to questions regarding application content. Community Health Promotion staff will not read the application prior to submission. Grant applications will be reviewed by a team of external and internal reviewers. Planning Grants will be scored separately to eliminate competition barriers for new applicants.

Funding decisions are based on application score, past performance, demonstration of need, appropriate expenses, population size, strength of plan, and applicant's ability to address health equity.

Award Administration Information - Chosen applicants will receive a Letter of Award and Grant Contract from the Kansas Department of Health and Environment. The first disbursement of grant funds may be expected on or before July 31, 2018. Any requested revisions to program activities, evaluation and/or budgets must be completed before the second disbursement of grant funds. Grant activities will be expected to start on July 1, 2018 and continue through June 30, 2019.

Grant Timeline

March	April	May	June	July	August
March 15, CDRR Grant application due	Review period	Award notices sent		July 1, Grant year begins, 25% of award funds distributed	August 15, revisions due
September	**October**	**November**	**December**	**January**	**February**
Bi-monthly call	October 1, 25% of award funds distributed	Bi-monthly call	Site Visit	January 1, 12.5% of award funds distributed January 15, mid-year report and financial status report due	February 15, 12.5% of award funds distributed
March	**April**	**May**	**June**	**July**	
Bi-monthly call	April 1, final 25% of award funds distributed	Bi-monthly call	June 30, Grant year ends	July 15, end of year report and financial status report due	

CHRONIC DISEASE RISK REDUCTION GOAL AREAS

The following section describes the goal/content areas covered in CDRR that will have the greatest impact to prevent chronic disease, including: tobacco use prevention and dependence treatment; access to healthy foods and physical activity opportunities, including community design strategies; and chronic disease self-management education programs.

Communities are encouraged to think about the community as a whole, with synergy across strategies. Non-traditional partners should be included in the planning and implementation. Applicants should use evidence-based strategies and best practices focused on policy, systems and environmental changes.

NOTE: To be funded for CDRR, at least one tobacco form (hereinafter referred to as a workplan) under Prevention or Secondhand Smoke must be selected. The remainder of topics are optional. Grantees are encouraged to select 1-5 high impact workplans to increase success.

PREVENT INITIATION OF TOBACCO USE AMONG YOUNG PEOPLE

The 2012 Surgeon General's Report shows that 99% of smokers begin smoking and using other forms of tobacco by age 26; limiting exposure and access is a key strategy to prevent tobacco use. Engagement of youth in tobacco control involves providing the opportunity for young people to gain the ability and authority to make decisions that help improve the policy environment, change social norms, and reduce smoking initiation and consumption in their communities.

Implementing comprehensive smoke-free school policies can benefit young people from all racial/ethnic and socioeconomic backgrounds equally and is a good way to target social determinants of health related to tobacco use to increase the quality of schools.[17] Comprehensive tobacco-free policies prohibit all forms of tobacco for students, staff, and visitors in school buildings, on school grounds and in school vehicles at all times. It is also recommended that comprehensive tobacco-free school policies prohibit tobacco use at off-campus school-sponsored events, add electronic cigarettes into the definition of prohibited products and prohibit tobacco industry sponsored materials (including tobacco clothing) and sponsorship. Opportunities to support cessation can include the Kansas Tobacco Quitline and other local resources.

In the tobacco retail setting marketing, advertising, and promotional strategies have been especially heavily marketed to low-income, minority, and young adult populations, making them a specific target of the tobacco industry and creating communities that are disproportionately susceptible to tobacco use.[18] Research has also shown that lower-income communities have higher amounts of tobacco advertising within 1,000 feet of schools compared to higher income communities, higher amounts of marketing and retailers impacts the amount of experimental smoking among students.[18] Increasing the minimum age of sale and purchase of tobacco products to 21 represents an opportunity for communities to further efforts to prevent initiation of tobacco use. A March 2015 Institute of Medicine study estimated that Tobacco 21 would reduce smoking among 15-17 year old by 25%, among 18 year olds by 15%, and among 19-20 year olds by 15% nationally.[19]

KEY RESOURCES:

- Best Practices User Guide; Youth Engagement - State and Community Interventions: http://stacks.cdc.gov/view/cdc/5628
- RESIST - The State Youth Tobacco Prevention Program: http://resisttobacco.org/
- Taking Down Tobacco - A comprehensive youth advocacy training program created by the Campaign for Tobacco-Free Kids: www.takingdowntobacco.org
- The Toll of Tobacco in Kansas by the Campaign for Tobacco Free Kids: http://www.tobaccofreekids.org/facts_issues/toll_us/kansas
- Model Tobacco Free Policy for Kansas Schools: http://www.publichealthlawcenter.org/sites/default/files/resources/Kansas-tobacco-free-schools-model-policies-2017.pdf

[17] Centers for Disease Control and Prevention. Best Practices User Guide: Health Equity in Tobacco Prevention and Control. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2015.

[18] Truth Initiative. Achieving Health Equity in Tobacco Control. December 8, 2015.

[19] IOM (Institute of Medicine). 2015. Public Health implications of raising the minimum age of legal access to tobacco products. Washington, DC: The National Academies Press. https://www.nap.edu/read/18997/chapter/1. Accessed November 17, 2017.

- Americans for Nonsmoker's Rights Resources: http://www.no-smoke.org/goingsmokefree.php?id=447
- Tobacco-free College Campus Initiative: http://tobaccofreecampus.org/resources
- Counter Tobacco-Policy Solutions: http://www.countertobacco.org/policy/
- Counter Tobacco-Store Assessment Tools: http://www.countertobacco.org/resources-tools/store-assessment-tools/
- ChangeLab Solutions-Tobacco Retailer Licensing: http://www.changelabsolutions.org/publications/tobacco-retailer-licensing
- National Tobacco 21: www.tobacco21.org
- Kick Butts Day: https://www.kickbuttsday.org/
- E-cigarettes & Young People – 2017 U.S. Surgeon General: https://e-cigarettes.surgeongeneral.gov/

***Note: All prevention workplans require youth participation.**

Prevention (1): Increase the number of youth engaged in tobacco control efforts. Must promote, recruit and train youth in the Taking Down Tobacco online training program (e.g., establishment of a youth tobacco coalition/Resist chapter, establishment of youth-adult partnerships on existing tobacco coalition, counter marketing campaigns)

Required Performance Measures:

1. Number of youth who have completed the Tobacco 101 online training course (found at Taking Down Tobacco website - http://www.takingdowntobacco.org/training-menu).
2. Number of youth who have completed all of the Taking Down Tobacco Become a Trainer courses: Taking Down Tobacco 101, Become a Trainer, and The Core 4 (Messaging Matters, Activities that Kick Butts, Informing Decision-Makers, and Mastering the Media).

Prevention (2): Increase the number of communities that adopt, strengthen and enforce policies that restrict youth access to tobacco products.

Required Performance Measures:

1. Number of youth who participate in retail-related strategies for tobacco use prevention
2. Number of policies passed during grant period that restrict youth access to tobacco products, including restrictions on flavored tobacco products, proximity of retailer to a school, or age of purchase.

Prevention (3): Increase the number of schools or school districts with 100% tobacco-free policies and plan for enforcement

Required Work Plan Performance Measures:

1. Number of school age youth who participate in tobacco use prevention activities
2. Proportion of schools or school districts with comprehensive[20] tobacco-free school grounds policies (provide both the total number of schools or school districts and the number of schools or school districts with comprehensive tobacco-free policies)
3. Proportion of school aged youth enrolled in a school or school district with comprehensive[20] tobacco-free school grounds policies (provide both the total number of school age youth

[20] Comprehensive tobacco-free policy for school districts are policies that prohibit the use of all tobacco products by anyone (including students, staff and visitors) on school property or at school events at all times. School property means all property whether owned, leased, rented or otherwise used by a school and includes buildings, grounds and vehicles.

enrolled in schools or school districts and the number of students enrolled in schools or school districts with comprehensive tobacco-free policies)

4. Proportion of staff employed by schools or school districts with comprehensive tobacco-free school grounds policies (provide both the total number of staff employed by schools or school districts and the number of staff employed by schools or school districts with comprehensive tobacco-free policies)

Prevention (4): Increase the number of colleges/universities with 100% tobacco-free policies and plan for enforcement

Required Performance Measures:

1. Number of college or university students who participate in tobacco use prevention activities
2. Proportion of post-secondary institutions with 100% tobacco-free or smoke-free college campus policies (provide both the total number of post-secondary institutions and the number of post-secondary institutions with smoke-free/tobacco-free campus policies).
3. Number of students protected by a 100% tobacco-free or smoke-free college campus policy
4. Number of staff protected by a 100% tobacco-free or smoke-free college campus policy

ELIMINATE NONSMOKERS' EXPOSURE TO SECONDHAND SMOKE

According to the Centers for Disease Control and Prevention (CDC), there is no risk-free level of exposure to tobacco smoke, including secondhand smoke; even brief exposure can be harmful to health. In the United States, it is estimated that 1 in 4 nonsmokers are exposed to secondhand smoke, and 2 in 5 children are exposed to secondhand smoke. For black children, those numbers are 7 in 10.[21]

Smoke-free policies can play an important role in protecting residents, especially children, from secondhand smoke (SHS) and preventing fires in multi-unit housing facilities. These policies protect residents from risks of developing heart disease, stroke, and lung cancer in adults, and Sudden Infant Death Syndrome (SIDS), lung problems, ear infections, and asthma attacks among children and babies.[21]

A key component of health equity work in tobacco control is eliminating secondhand smoke exposure disparities between groups.[22] Comprehensive tobacco control policies that are well-enforced help to reduce tobacco related disparities. Policies to reduce secondhand smoke exposure include comprehensive smoke-free policies in multi-unit housing, parks and outdoor areas, and in worksites. It is important to protect all population groups and not include exceptions or loopholes in policies that might leave some groups exposed.

KEY RESOURCES

- Americans for Nonsmokers' Rights - Resources & Tools for Smoke free Multi-Family Housing: http://www.no-smoke.org/pdf/MUHresources.pdf

[21] Centers for Disease Control and Prevention. Going Smoke-Free Matters. https://www.cdc.gov/tobacco/infographics/policy/pdfs/going-smokefree-matters-multiunit-housing-infographic.pdf

[22] Centers for Disease Control and Prevention. Best Practices User Guide: Health Equity in Tobacco Prevention and Control. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2015. https://www.cdc.gov/tobacco/stateandcommunity/best-practices-health-equity/pdfs/bp-health-equity.pdf

- Americans for Nonsmokers' Rights - Getting Started on Smoke free Multi-Family Housing: http://www.no-smoke.org/pdf/MUHgettingstarted.pdf
- CDC: Going Smoke Free Matters Multi-Unit Housing: https://www.cdc.gov/tobacco/infographics/policy/pdfs/going-smokefree-matters-multiunit-housing-infographic.pdf
- US Department of Housing and Urban Development (HUD) Guidebook (2017): https://www.hud.gov/sites/documents/SMOKEFREE_GUIDEBK.PDF
- HUD Action Guide (2014): https://www.hud.gov/sites/documents/SFGUIDANCEMANUAL.PDF
- HUD Public Housing Authority Contacts: http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/pha/contacts/ks#footnote
- Tobacco Free Wichita Smoke-Free Housing Initiative: https://tobaccofreewichita.org/smoke-free-housing-initiative/
- ChangeLab Solutions Smoke-free Housing: http://www.changelabsolutions.org/landing-page/secondhand-smoke
- Public Health Law Center Smoke-free & Tobacco-free Places (Housing, Outdoors, Schools, Workplaces): http://publichealthlawcenter.org/topics/tobacco-control/smoke-free-tobacco-free-places
- The American Cancer Society – Creating a Smoke-free Workplace: https://www.cancer.org/healthy/stay-away-from-tobacco/smoke-free-communities/create-smoke-free-workplace.html
- ChangeLab Solutions Smoke-free workplaces & outdoor areas: http://www.changelabsolutions.org/landing-page/smokefree-workplaces-and-outdoor-areas
- Utah Tobacco-Free Workplace Toolkit: http://www.tobaccofreeutah.org/pdfs/shsworksitekit.pdf
- Tobacco-free Parks: http://www.tobaccofreeparks.org/documents/Creating_Healthy_Communities.pdf
- Young Lungs at Play: http://www.coginc.org/Resources/04-%20YLAP%20Fact%20Sheet.pdf
- Policy Strategies: A Tobacco Control Guide: http://cphss.wustl.edu/Products/Documents/CPHSS_TCLC_2014_PolicyStrategies1.pdf
- Public Health Law Center - Tobacco Control: http://www.publichealthlawcenter.org/topics/tobacco-control

Secondhand Smoke (1): Increase the number of multi-unit dwellings with smoke-free policies in combination with cessation support

Required Performance Measures:

1. Proportion of multi-unit housing complexes with 100% smoke-free in all units, including balconies and patios where applicable.[23]
2. Proportion of multi-unit housing complexes with partial smoke-free policies. Partial smoke-free policies include apartment complexes that have smoke-free units but policies do not cover 100% of all units (i.e., only some buildings or sections of buildings have smoke-free units).[24]
3. Proportion of units covered by smoke-free policies in multi-unit housing complexes.[25]
4. Proportion of multi-unit housing residents covered by smoke-free policies.[26]

[23] Provide both the total number of multi-unit housing complexes and the number of multi-unit housing complexes with 100% smoke-free policies in all units.
[24] Provide both the total number of multi-unit housing complexes and the number of multi-unit housing complexes with partial smoke-free policies.
[25] Provide both the total number of units and the number of units covered by smoke-free policies.
[26] Provide both the total number of multi-unit housing residents and the number of multi-unit housing residents covered by smoke-free policies.

5. Number of multi-unit housing complexes that serve low-income residents with all or some rental units being smoke-free (i.e., Public Housing Authorities, Section 8).

Secondhand Smoke (2): Increase the number of tobacco-free policies in worksites, in combination with cessation and enforcement support, with a focus on low wage worksites.

Required Performance Measures:

1. Total number of new tobacco-free policies adopted across all worksites.
2. Total number of new tobacco-free policies in low wage worksites.
3. Proportion of targeted employers in city/county implementing a new worksite tobacco-free policy.
4. Proportion of employees impacted by implementation of a new worksite tobacco-free policy.

Secondhand Smoke (3): Increase the number of tobacco-free policies in settings where people gather, (e.g., parks, trails, farmers markets, sports arenas and outdoor work areas)

Required Performance Measures:

1. Proportion of city/county parks/recreation sites that currently have smoke-free/tobacco-free policies (provide both the total number of city/county parks/recreation sites and the number of city/county parks/recreation sites that currently have smoke-free/tobacco-free policies).

2. Proportion of parks/recreation sites that currently have smoke-free/tobacco-free policies in areas accessed by disparate populations (e.g., low income). Provide both the total number of parks/recreation sites and the number of city/county parks/recreation sites that currently have smoke-free/tobacco-free policies in areas accessed by disparate populations.

PROMOTE QUITTING AMONG ADULTS AND YOUNG PEOPLE

NOTE: Promotion of the "Brief Tobacco Intervention" (BTI) web-based training to local providers must be incorporated into the workplan(s) that you choose in the Cessation Goal Area. A brief description of the BTI web-based training can be found in the key resources section.

Tobacco dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit. Effective treatments exist, however, that can significantly increase rates of long-term abstinence.[27] More than 80% of smokers see a physician every year, and most smokers want and expect their physicians to talk to them about quitting smoking and are receptive to their physicians' advice.[28] "The Clinical Practice Guideline: Treating Tobacco Use and Dependence" recommends providing tobacco users information on quitting techniques, pharmacotherapies and cessation counseling.[27]

KEY RESOURCES:

- Brief Tobacco Intervention Online Training: www.kstobaccointervention.org

[27] Treating Tobacco Use and Dependence: 2008 Update. Tobacco Use and Dependence Guideline Panel. Rockville, MD: US Department of Health and Human Services: 2008 May. Accessed November 20, 2017.

[28] Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs – 2014. Atlanta: US Department of Health and Human Services, 2014. Accessed November 20, 2017.

- The Clinical Practice Guideline: Treating Tobacco Use and Dependence: 2008 Update: https://www.ncbi.nlm.nih.gov/books/NBK63952/
- Smoking Cessation for Pregnancy and Beyond: A Virtual Clinic (a free interactive multimedia program based on the "Virtual Practicum" model): www.smokingcessationandpregnancy.org
- Dimensions: Tobacco-free Toolkit for Healthcare Providers: http://www.bhwellness.org/toolkits/Tobacco-Free-Toolkit.pdf
- A Practical Guide to Working with Health-Care Systems on Tobacco-Use Treatment: https://www.cdc.gov/TOBACCO/quit_smoking/cessation/pdfs/practical_guide.pdf
- Help Your Patients Quit Tobacco Use: An Implementation Guide for Community Health Centers: http://www.smokefreeoregon.com/wp-content/uploads/2011/01/LEG-Community-Health-Report-Inside-Final-10-11-13.pdf
- Smoking Cessation Leadership Center Toolkits: https://smokingcessationleadership.ucsf.edu/behavioral-health/resources/toolkits

Cessation (1): Promote adoption of the *Kansas Tobacco Guideline for Behavioral Health Care* by behavioral health care facilities.*

Required Performance Measures:

1. Number of facilities that adopt the *Kansas Tobacco Guideline for Behavioral Health Care*.
2. Number of facilities that establish a new policy, systems or environment change that includes the KDHE "Brief Tobacco Intervention" web-based provider training.
3. Number of behavioral health providers in target locations who complete the KDHE "Brief Tobacco Intervention" web-based provider training.
4. Number of individuals referred to the Kansas Tobacco Quitline phone or web-based service by a healthcare professional.

Cessation (2): Establish tobacco dependence screening, referral and treatment systems within clinics.

Required Performance Measures:

1. Number of clinics that establish a systems change to adopt or improve tobacco dependence treatment including screening, referring and providing brief tobacco dependence treatment.
2. Number of clinics that serve the medically underserved patient population (e.g., Kansas Association of Medically Underserved clinics) that establish a systems change to adopt or improve tobacco dependence treatment including screening, referring and providing brief tobacco dependence treatment.
3. Number of clinic providers who complete the KDHE "Brief Tobacco Intervention" web-based provider training.

Cessation (3): Establish tobacco cessation screening, referral and counseling systems targeting healthcare providers serving women during the perinatal period. Examples of interventions include: increasing KanQuit online enrollment using a "warm handoff" model in WIC clinics; implementation of an evidence-based smoking cessation program (i.e.; SOPHE Smoking Cessation Reduction in Pregnancy Treatment - SCRIPT®, Baby and Me Tobacco Free - BMTF) or establishing a Brief Tobacco Intervention training policy requirement.

1. Number of health care provider organizations that establish a systems change to adopt or improve practices for tobacco dependence treatment during pregnancy including screening, referring and providing brief tobacco dependence treatment.

2. Number of health care provider organizations that establish a new policy, systems or environment change that includes the KDHE "Brief Tobacco Intervention" web-based provider training.
3. Number of health care providers in target locations who complete the KDHE "Brief Tobacco Intervention" web-based provider training.
4. Number of women who are currently pregnant, planning pregnancy or currently breastfeeding who enroll in the Kansas Tobacco Quitline.
5. If SCRIPT or BMTF selected: Number of staff who successfully complete SCRIPT® or BMTF program training.
6. If SCRIPT or BMTF selected: Number of women who participate in SCRIPT® or BMTF program.
7. If SCRIPT or BMTF selected: Number of women who abstain from smoking throughout pregnancy.

***Communities funded for Cessation 1 may be eligible for funding to cover the costs of up to 5 behavioral health providers to complete the Tobacco Treatment Specialist Training (TTS) through UMass (up to $10,000) OR to host KU Medical Center TTS training on-location (up to $20,000).**

PHYSICAL ACTIVITY, ACCESS TO HEALTHY FOODS, AND COMMUNITY RESILIENCY (PAN)

Physical inactivity and poor nutrition are two of the three main risk factors leading to multiple chronic diseases, including heart disease, stroke, and some cancers. Whether or not people engage in physical activity and healthy diets is the result of many factors, including culture, socioeconomic status, and the built environment. Disparities in health outcomes among different populations are exacerbated by policy and environmental barriers to healthy food and physical activity access. Increasing access to physical activity opportunities and healthy food, and thereby decreasing the prevalence of chronic diseases, requires a coordinated and comprehensive approach that engages underserved populations in identifying needs and solutions, works with and through diverse sectors and partners in the community, and implements policies, systems and environments supportive of healthy food and physical activity access, especially for underserved populations.

KEY RESOURCES:

- The Community Guide: https://www.thecommunityguide.org/
- Surgeon General's Call to Action to Promote Walking and Walkable Communities: https://www.surgeongeneral.gov/library/calls/walking-and-walkable-communities/index.html
- The Case for Healthy Places: Improving Health Outcomes through Placemaking: https://www.pps.org/wp-content/uploads/2016/12/Healthy-Places-PPS.pdf
- Public Health Law Center - Kansas Resources: http://publichealthlawcenter.org/topics/special-collections/kansas-resources
- Smart Growth America: http://www.smartgrowthamerica.org/
- ChangeLab Solutions: http://www.changelabsolutions.org/
- Dietary Guidelines 2015-2020 Eighth Edition: http://health.gov/dietaryguidelines/2015/guidelines/
- The Food Trust: http://thefoodtrust.org/
- Surgeon General's Call to Action to Support Breastfeeding: https://www.surgeongeneral.gov/library/calls/breastfeeding/index.html

Physical Activity & Nutrition (1): Establish new food policy councils and/or implement one or more food policy council priorities that advance policy, system, and environmental changes to support a healthy food system and improved food access.

1. If the workplan involves establishing new food policy council(s) report: Number of jurisdictions covered by newly formed food policy councils.
2. Number and type of food policy council priorities implemented that advance policy, system, and environmental change to support healthy food system and food access.
3. Number of adults impacted by the food policy council priorities implemented that advance policy, systems, and environmental change to support healthy food system and food access.
4. Number of food policy council priorities addressing needs of the disparate population(s).

Physical Activity & Nutrition (2): Form or strengthen bike/walk planning advisory committees to coordinate local community design policy efforts and awareness activities.

Required Performance Measures:

1. Number of municipalities where new bike/walk planning advisory committees are adopted.
2. Number and type of organizations represented on bike/walk planning advisory committees.
3. Number of policies enacted that include language that supports environmental changes to enhance places for physical activity, emphasizing walking.

Physical Activity & Nutrition (3): Adopt and/or implement community-wide and/or site-specific design standards to increase active transportation (e.g., Complete Streets, Master bike/ped plans, etc.) and access to services and resources. Planning focus should be on destination-based routes.

Required Performance Measures:

1. Number and type (community-wide or site-specific) design standards that are adopted and/or implemented to increase active transportation and access to services and resources, especially among disparate populations.
2. For Community-Wide Design Standards: Number of residents in a jurisdiction with community-wide design standards that are adopted and/or implemented to increase active transportation and access to services and resources, especially among disparate populations.
3. For Site-Specific Design Standards: Number of residents utilizing sites that adopt and/or implement site-specific design standards to increase active transportation and access to services and resources, especially among disparate populations.

Physical Activity & Nutrition (4): Improve public spaces by developing/implementing a creative placemaking project and/or repurpose infrastructure and vacant property, to increase community physical and nutritional health, resiliency, and economic diversification, with a focus on equitable access for priority populations.

Required Performance Measures:

1. Number and type of existing infrastructure or vacant properties acquired for repurposing.
2. Number of each type of repurposed properties (e.g., fitness facility, community center, food market, pop-up shop, or other start-up).
3. Number and type of community partners engaged in the development and implementation of Creative Place-making Plan(s) and/or acquiring and repurposing existing infrastructure or vacant properties.

Physical Activity & Nutrition (5): Promote and support breastfeeding using one or more of the following strategies: develop systems to guarantee continuity of skilled support for lactation between hospitals and health care settings in the community; ensure that worksites establish and maintain comprehensive, high-quality lactation support programs for their employees; provide breastfeeding education for health clinicians who care for women and children.

Required Performance Measures:

1. Proportion of infants ever breastfed (WIC data)
2. Proportion of infants exclusively breastfed at 6 months (WIC data)
3. If worksite focused: Number of employers receiving the "Breastfeeding Employee Support Award" (KBC database)
4. If systems focused: Number of local breastfeeding coalitions (KBC database)
5. If systems focused: Number of peer support groups (KBC database)
6. If systems focused: Number of "Breastfeeding Friendly Physician Practices" (KS AAP website)
7. If education focused: Number of health clinicians who completed breastfeeding/lactation continuing education

INCREASE THE ABILITY OF THOSE WITH CHRONIC DISEASE TO MANAGE THEIR CONDITION(S)

Chronic Disease Self-Management Education programs are evidence-based curricula developed by Stanford University and licensed by the Self-Management Resource Center. KDHE is one of two license-holders in Kansas to implement these programs. Workshops are once a week for six weeks and led by two trained leaders, one of whom is living with a chronic condition. Workshops are recommended for anyone living with one or more chronic conditions, family or friends of those living with a chronic condition as well as caregivers. These interactive workshops provide participants with techniques to deal with symptoms such as pain, fatigue and depression associated with chronic conditions. Participants also learn and practice problem-solving and action planning.

CDSME (1): Promote and coordinate the expansion of CDSME programming opportunities and their reach

Required Performance Measures:

1. Number of organizations coordinating and implementing one or more CDSME workshop(s) consistently (i.e., one or more workshop per year). CDSME programs include the Chronic Disease Self-Management Program or Diabetes Self-Management Program.
2. Number of potential delivery partners
3. Number of community organizations referring to workshops (include names of community organizations).
4. Number of providers referring to workshops through a trackable referral system (a trackable referral system includes systems, such as Electronic Health Records or the KDHE bi-directional referral process that allows providers to track when referrals are sent and if referred patients attend and/or complete the CDSME program).

KEY RESOURCES:

- Self-Management Resource Center: https://www.selfmanagementresource.com/
- Kansas Department of Health and Environment, Tools for Better Health: www.ToolsForBetterHealthKS.org
- Kansas Self-Management Education: www.SelfManageKS.org

Note: Media material must include the KDHE logo to comply with the Stanford licensing guidelines. All media material must be sent to and approved by KDHE before distributing.

Recommended Action Steps: Identify a local CDSME program coordinator. Coordinator will:

1. Provide TA to local leaders and organizations while they coordinate and implement workshops.
2. Assist in marketing/promotion efforts (e.g., distribute educational materials to recruit participants, leverage earned media to recruit delivery partner organizations and participants)
3. Ensure that CDSME leaders send workshop forms to the Kansas Foundation for Medical Care via mail or secure email.
4. Engage **one or more organizations** to commit to being delivery-system partners who will work to implement and coordinate CDSME workshops one or more times a year, and is willing to have a CDSME Champion within that organization to coordinate CDSME efforts.
5. Work with KDHE CDSME Coordinator to identify and recruit **one or more health care providers** as referral partners.

Application Instructions

Incomplete applications will not be considered.
Please direct any questions to your regional Community Health Specialist. Grantees are encouraged to have assigned Community Health Specialist review application at least 48 hours prior to submission to ensure application is complete.

The application will be completed using the Kansas Grant Management System. First time applicants may contact Karen Kelley, Kansas Grant Management System Manager, at Karen.Kelley@ks.gov for information about using KGMS.

Once a KGMS account is secured, applicants may select the Chronic Disease Risk Reduction SFY2019 application, fill in requested information and attach the below completed supplemental forms in the Kansas Grant Management System.

Refer to the CDRR Scoring Guidance while writing your application.

Application Forms (completed separately and uploaded into the Kansas Grant Management System)

Implementation applicants must complete the following forms: Coalition Membership and Salary Worksheet

Coalition Membership Form

a. A functional coalition is a requisite for successful community-based chronic disease prevention.
b. Sectors of community support are provided as a guideline for composition of an optimal community coalition.
c. Applicants should include all sectors with direct relevance to selected goals and outcomes. Each sector may have multiple participants.

Salary Worksheet:

a. List the employee name and title for each proposed staff member. Complete salary spreadsheet and enter information in blank fields indicating number of hours worked per week, percentage of time spent on grant, salary and allocation of time allocated to

tobacco use prevention, physical activity and nutrition, and chronic disease self-management. Fields will automatically populate based on information entered.

b. Grant funds for staffing are to be used for grant coordination and activity implementation through local health educators/outreach workers.
c. No more than 10 percent of administrators' salaries may be funded by CDRR.

Planning Applicants Only: Complete (1) Connection Map, Identifying Linkages between Community Priorities and Tobacco Control, Types and Levels of Partnerships-one fillable PDF, **(2)** -Planning Applicants Only form within KGMS and **(3)** - budget within KGMS.

For both planning and implementation applicants who are not local health departments: Obtain a letter from the local county health department designating applicant agency and upload it with the other required forms.

Implementation Applicants are required to complete the Administration section in KGMS. Every field in the Administration form in KGMS is indicated below:

Administration

a. Fields to be completed:
    i. Counties to be served
        - Select the counties to be served in the proposed workplans.
    ii. Community Profile and Statement of Need
        - Provide a clear and specific description of the community that includes data from existing sources on community demographics and the prevalence of behaviors and/or chronic diseases.
        - Grantees are required to utilize existing data sources in planning their application. The community profile and statement of need should describe how information from the existing data sources justify their selected workplans and target populations. Below are a list of recommended data sources that should be used in addition to other community level data that may be available (e.g., Kansas Tobacco Quitline reports, food policy council assessment, existing community health assessment, etc.).
            - Recommended data sources:
                - Kansas Behavioral Risk Factor Surveillance System: This data sources provides prevalence for chronic diseases and their associated risk factors in the overall population and in target population subgroups. Data are available at the state, regional, and county level.
                    - Local-level reports: http://www.kdheks.gov/brfss/HRSReports/local_hrs_reports_index.htm
                    - Local-level data: http://www.kdheks.gov/brfss/BRFSS2015/index.html
                    - State-level data: http://www.kdheks.gov/brfss/
                - Kansas Information for Communities: This website provides access to information about population demographics and vital statistics.

        - http://kic.kdheks.gov/
    - American Fact Finder: This website provides access to information about population demographics and socioeconomic characteristics. One particularly useful link on this page is General Economic Characteristics. This provides information about poverty and housing characteristics and is available at the community level.
        - https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml
    - Kansas Annual Summary of Vital Statistics: This report provides information about smoking during pregnancy at the county level in addition to other relevant vital statistics information (e.g., births, deaths).
        - Link to the 2016 report: http://www.kdheks.gov/phi/as/2016/Annual_Summary_2016.pdf
    - Kansas Health Matters: This is a clearinghouse website that contains information from a variety of sources, including some selected information from the Kansas Behavioral Risk Factor Surveillance System and the KDHE Office of Vital Statistics.
        - http://www.kansashealthmatters.org/
- Provide a clear and full explanation of how the funds will benefit the community through the selected workplans.

iii. Community Capacity
- Describe plan for staff, partnership collaboration, resources, and necessary training and tools needed to support the workplans.

iv. Health Equity
- Provide details on community plan for engaging and impacting populations experiencing preventable health inequities and how your community will work to advance health equity community-wide.

Interventions to Improve Public Health – NOTE: To be funded for CDRR, at least one tobacco workplan under Prevention or Secondhand Smoke must be selected. Cessation, Physical Activity and Nutrition and Chronic Disease Self-Management workplans are optional. Grantees are encouraged to pick a total of 1-5 high impact workplans to increase success.

Applicants should opt out of the workplans that are not selected for implementation.

a) Required Fields for each workplan selected:
   i. Multi-year SMART Objective
      - Multi-year Objective must be SMART - Specific, Measurable, Achievable and Time-bound.
      - The multi-year objective will lead to progress on required performance measures and be clearly tied to the workplan.
      - SMART format: "By [date], increase or decrease [y] to [x]."
   ii. Annual SMART Objective
      - Annual Objective must be SMART - Specific, Measurable, Achievable and Time-bound.

- The annual objective should ultimately lead to progress on multi-year objective and required performance measures.

iii. Target Population
- Describe and quantify the group of people this activity will help. Applicants should be using existing data sources. Please see the list of recommended sources above.

iv. Target Organization
- List organizations this activity will impact. If you plan to help students, then the organization would be the schools you plan to work with. If you want to work with employees, then the organization would be their employer.

v. Action steps (5-10 Steps)
- Action steps are purposeful, logical and will lead to significant progress on objectives.

vi. Communications
- Describe proposed earned media, social media, public relations efforts and paid media activities if applicable.

vii. Performance Measures and Data Sources
- Required performance measures for each workplan are auto-filled in KGMS. Include data sources that will be used to address the required performance measures.
- Where applicable, applicants are encouraged to include a limited number of additional quantitative process measures to evaluate progress towards reaching the annual objective and required performance measures. Focus on 1 to 3 important measures. Consider including a measure that addresses how underserved populations are engaged or reached.

viii. Evidence and Long-Term Impact
- Describe how workplan is evidence-based, linked to sustainable policy, systems or environmental changes, shows synergy with other work in the community and appears very likely to produce significant long-term positive impact.

Budget:

d. General Budget: All applicants must complete a budget
   a. Complete the budget line items within the grant management system providing the necessary financial information in the Salary/Personnel, Benefits, Supplies, Travel, Subcontractors, and Paid Media categories. Provide a complete description of staff responsibilities and justification for expenditures.